Human rights and mental health care – towards effective contribution of psychiatry to the realization of the CRPD

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Momentum

- Importance of mental health and mental healthcare – increasingly recognized
- From MDGs to SDGs. Global agenda 2030
- Addressing mental health and human rights globally, regionally, nationally - within and beyond mental health services
- Migrant and refugee crisis and other societal challenges – related to mental health
- Challenges and opportunities in the post-CRPD era
- All stakeholders, including psychiatric profession, should rethink on important issues and on their role

Lessons from history

- Important paradigm shifts in history of psychiatry during last centuries (including shifts from “mindless brain” to “brainless mind” and other way around)
- The need to reconsider balance between biomedical and social models/interventions
- World health report (2001) - mental health needs to be liberated from isolation and stigma. WHO Mental health action Plan (2013-2020). Lancet commission report (2018)
- The need to be guided by modern public health approach and human rights based approach
- Relations between psychiatry and human rights movement has always been not easy. Good news is that these relations have been gradually improving, as psychiatry was learning painful lessons of human rights abuses and advancing with human rights approach.

Human rights and mental health

- Universal Declaration of Human Rights (1948)
- UN Conventions and mechanisms for monitoring (CESCR, CCPR, CAT, CEDAW, CRC and others). Treaty bodies and independent experts (UN Special rapporteurs)
- All human rights (cultural, civil, economic, political, social) are equally important. They are indivisible and interdependent.
- Recent years - universal human rights principles under attacks globally. The need for broad coalition of those who defend human rights of everyone, especially of persons in vulnerable situations.
- Things may go wrong when human rights are undermined or addressed in selective way. Example – selective approaches used in “East” and “West” during the Cold war. For mental health, it is equally detrimental to undermine social/economic rights or civil/political rights and freedoms
- Right to physical and mental health can be effectively protected and promoted only if a human rights based approach (HRBA) is applied fully, and not in a selective way.

RIGHT TO HEALTH MANDATE

- Mandate established in 2002. Paul Hunt (2002-2008), Anand Grover (2008-2014)
- This mandate is a part of UN Special Procedures mechanism
- Objectives:
  - Promote and clarify right to health and rights-based approach to health
  - Identify good practices, inform about challenges and obstacles, provide recommendations
- Not right to be healthy, but right to the enjoyment of the highest attainable standard of physical and mental health
- Not just right to medical care, but also right to determinants of health (e.g., poverty, violence, discrimination)
- Working methods: country missions, thematic reports to UN GA and HRC, communications, non-mandated activities
- http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx

Right to health – elements of analytical framework

- national and international human rights laws, norms and standards
- resource constraints and progressive realization
- obligations of immediate effect
- **freedoms and entitlements**
- **healthcare – available, accessible, acceptable and good quality**
- obligation to respect, protect, fulfil
- **non-discrimination, equality and vulnerability**
- **active and informed participation**
- international assistance and cooperation
- **monitoring and accountability**

Convention on the right of persons with disabilities (CRPD)

- Dignity and autonomy
- Equality and non-discrimination
- Effective participation and inclusion
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality of opportunity
- Social vs medical model: obstacles are outside, they need to be removed through empowerment, inclusion, participation and non-discrimination. Tensions between CRPD principles and prevailing biomedical approaches in psychiatry

Concerns, disagreements, misunderstandings

- Impasse around controversy: do involuntary psychiatric measures violate international human rights law? Are they based on evidence and are they effective?
- Shall we continue investing in status quo or do mental health policies and services need another paradigm shift?
- Role of psychiatry in the process. Focus on exceptional cases which seem unmanageable without coercion? Or commit to substantially reducing coercion which is on the rise in numbers?
- Polarization of views by experts and organizations – reflected in responses to the report of the Special rapporteur in 2017 What could that mean? Is a consensus possible?
- Disagreements may be based on misunderstandings and lack of information
- Disagreements on basic principles and substantial issues. What is the role of important stakeholders (such as psychiatric profession) when retrogressive decisions and measures are undertaken?

Concerns, disagreements, misunderstandings

- UN Human Rights Council resolutions (2016, 2017) on mental health and human rights: too often users of mental health services suffer from human rights violations
- Europe: Unacceptably high number of children and adults with intellectual and psychosocial disabilities are living in large residential institutions.
- Culture of mental health services in many parts of the world, including WHO European region remains paternalistic and undermines human rights principles. Serious changes are still to happen, including serious attitude to human rights and ethics, de-institutionalization, investing in mental health promotion and psychosocial interventions
- Independent monitoring of human rights in mental health facilities is still not in place in many countries
- Independent experts express concern over different forms of violation of human rights in mental healthcare services
- Europe should continue and strengthen its leadership in human rights and proactively address challenges within and beyond mental health services

Mental health policies and services in Central and Eastern Europe: High cost of undermining human rights based approach

- The system was and remains extremely medicalized, undermining human rights and evidence
- All stakeholders, including psychiatry, are hostages of policies guided by interests of certain groups in power and "historical" principle of allocation of resources (institutional care, psychiatric hospitals, excessive use of medications)
- CEE region has the highest numbers of institutionalized children and adults in the world. CRPD is ratified, but no will so far (with some exceptions) to take seriously main principles
- In many of new EU member states EU structural funds have been massively used to renovate large residential care facilities and psychiatric hospitals
- Psychiatric professional group too often is using its power to keep status quo in the system rather than to abandon outdated practices
- Winkler P. et al. (2017) A blind spot on the global mental health map: a scoping review of 25 years' development of mental health care for people with severe mental illnesses in central and eastern Europe
- Regional differences – what messages are regions and countries receiving from more advanced countries and regional/national professional societies? Quality of exchange and cross-fertilization of practices

Report of the Special rapporteur to UN Human Rights Council – June 2017

- Global burden of obstacles highlighted – as alternative view to medicalized concept of "global burden of diseases" (in line with the CRPD)
- Three main groups of obstacles identified. They need to be seriously addressed:

- Dominance of biomedical model and overuse of biomedical interventions
- Power asymmetries
- Biased use of knowledge and evidence

A need for meaningful debate around deprivation of liberty in psychiatry and involuntary treatment

Prevailing view among psychiatric profession and policy makers:

Psychiatrists as experts decide when they should step in with using force (non-consensual measures) treatment (as medical necessity) and prevention of dangerousness. This is their duty to provide treatment, even if against will, and thus to secure right to health. Psychiatry is a specific field, in which such exceptions are unavoidable.

Only through providing treatment we may ensure that persons with psychosocial disabilities continue living in dignity

Prevailing view among human rights advocates and UN mechanisms:

Deprivation of liberty and forced treatment, according to CRPD, should be banned. Alternative approaches should be developed and replicated. There should be no exceptions, because exceptions in everyday practice use to turn into the rule, and thus psychiatry and mental healthcare facilities continue to be an unacceptable space for systemic human rights violations.

Dignity cannot be compatible with practices of forced placement and treatment which may amount to ill-treatment and torture

Issues for serious debate and search of compromise

- If there is no hierarchy of rights, and if a right to receive effective treatment and a right to be free from violence and deprivation of liberty are equally important, how then to proceed in the situation of psychiatric emergencies?
- Is the argument of applying involuntary measures because of "dangerousness" strong enough?
- Is the argument of applying involuntary measures because of "medical necessity" strong enough?
- Supported vs. substitute decision making
- Different views to "status quo" and need for change: impact on trust, therapeutic alliance, and image and reputation of psychiatry
- What could be a new role and mission of psychiatry with regard to a new paradigm shift ?
- Defensive position of psychiatry is perceived by other stakeholders as an obstacle for systemic change

Challenges of further development with two scenarios

Supporting and investing in "Status quo"

May lead to the scenario when CRPD is undermined, and persons with psychosocial disabilities continue to be deprived of their rights and subjected to deprivation of liberty and interventions which are not necessarily effective

This scenario may reinforce vicious cycle of systemic failures and also be detrimental to image and reputation of psychiatry.

Is it possible to abandon, in a manner of progressive realization, human rights violations, including forced placement and treatment in psychiatry, with tools which are in place? If yes, so why this is not happening?

Ban of non-consensual practices in mental health care:

May lead to situation when these legal provisions are never enforced by states, or – if they are enforced, there is no willingness by stakeholders to implement them, or this implementation fails for other reasons

Examples of rights based (non-coercive) services do exist in Europe and worldwide, however there is reluctance from main actors to accept, replicate and mainstream them

Is it possible to find compromise between different views within this discourse?

How this challenge should be addressed by psychiatric profession?

- One way is to disqualify position of CRPD committee expressed in its General Comment N.1 and arguments of human rights advocates and to use influence on policy makers to keep status quo in mental health care
- Another way is to accept this challenge as a unique opportunity for change and for shift of paradigm:

To recognize that psychiatry is facing crisis, and to rethink position of profession with regard to human rights, social control, non-consensual measures, neurobiological paradigm and other conventional wisdoms

To form effective alliances with those willing to develop innovative approaches and to lead the process of modernizing philosophy and practice of what modern mental health policies and services are and what they should and should not be

Report of SR to UN HRC (2017) – key messages and recommendations

- Ensure that users are involved in the design, implementation, delivery and evaluation of mental health services, systems and policies;
- Stop directing investment to institutional care and redirect it to community-based services;
- Invest in psychosocial services that are integrated into primary care and community services to empower users and respect their autonomy;
- Scale up investment in alternative mental health services and support models;
- Develop a basic package of appropriate, acceptable (including culturally) and high-quality psychosocial interventions as a core component of universal health coverage;
- Take targeted, concrete measures to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement;
- Seek technical assistance from the WHO QualityRights initiative to assess and improve the quality of mental health care.

Broad spectrum of responses to the report – reflection of the situation in global mental health

What is expected from psychiatric profession as an important stakeholder?

- Join the process of developing, expanding and mainstreaming rights based services and be among leaders of this process
- Contribute to reducing coercion, institutionalization and over-medicalization in mental health care
- Contribute to reducing power asymmetries in mental healthcare
- Support movements of users of mental health services and take into account valuable knowledge from experts by lived experiences
- Advocate for laws and policy measures that could substantially reduce coercion in psychiatry and fully integrate the principles of the CRPD